Mother's or Infant's Name (in case of page separation):

HOSPITAL INFORMATION

37. NAME AND ADDRESS OF BIRTH HOSPITAL:

38. MOTHER'S MEDICAL RECORD AT BIRTH HOSPITAL:

39. INFANT'S MEDICAL RECORD AT BIRTH HOSPITAL:

40. NAME AND ADDRESS OF TRANSFER HOSPITAL:

41. INFANT'S MEDICAL RECORD AT TRANSFER HOSPITAL:

42. DATE OF TRANSFER TO TRANSFER HOSPITAL:

PHYSICIAN INFORMATION

43. NAME AND ADDRESS OF MOTHER'S PHYSICIAN:

44. TELEPHONE NUMBER OF MOTHER'S PHYSICIAN: *(with area code)*

45. NAME AND ADDRESS OF INFANT'S PHYSICIAN:

46. TELEPHONE NUMBER OF INFANT'S PHYSICIAN: *(with area code)*

BIRTH DEFECT DIAGNOSIS

A. CHROMOSOMAL ABNORMALITIES

Do not report: a) Heterochromatin Variants; b) Satellite/Stalk Variants of Chromosomes 13,14,15,21,22; c) Inv(2) (p11;q13); d) Inv (9) (p11;q12 or q13); e) Familial Y Variants; or d) Pse

47. CYTOGENETIC DIASNOSIS *(ISCN Short Form)*

48. INHERITANCE OF STRUCTURAL REARRANGEMENTS:
- ☐ DE NOVO
- ☐ PATERNAL
- ☐ MATERNAL
- ☐ UNKNOWN

49. CYTOGENETIC LAB SPECIMEN NUMBER:

50. LAB NAME:

51. SPECIMEN TYPE:
- ☐ AMNIOTIC FLUID
- ☐ CHORIONIC VILLUS (CVS)
- ☐ PERCUTANEOUS UMBILICAL BLOOD
- ☐ ABORTUS SPECIMEN
- ☐ STILLBORN TISSUE/BLOOD
- ☐ LIVEBORN BLOOD
- ☐ LIVEBORN TISSUE
- ☐ LIVEBORN CORD BLOOD
- ☐ LIVEBORN BONE MARROW
- ☐ OTHER *Specify:*

52. SAMPLING DATE *Check if final result date used* ☐

53. GESTATIONAL AGE AT TIME OF SAMPLING: *(Prenatal: Abortus, Fetal Demise or Stillborn only)* Weeks /Days

54. METHOD USED TO DETERMINE GESTATIONAL AGE AT TIME OF SAMPLING:
☐ LMP ☐ ULTRASOUND ☐ EXAM

55. REASON FOR SAMPLE:
☐ DYSMORPHIC FEATURES ☐ CONGENITAL ABNORMALITIES ☐ CONFIRMATION OF PRENATAL DIAGNOSIS ☐ OTHER

B. NEURAL TUBE DEFECTS

56. NEURAL TUBE DEFECT DIAGNOSIS: *(ICD 9 Codes 740.0-742.0)*
- ☐ ANENCEPHALY
- ☐ RACHISCHISIS
- ☐ CRANIORACHISCHISIS
- ☐ INIENCEPHALY
- ☐ ENCEPHALOCELE
- ☐ MYELOMENINGOCELE
- ☐ ACRANIA
- ☐ EXENCEPHALY
- ☐ MECKEL GRUBER
- ☐ UNSPECIFIED
- ☐ OTHER *Specify:*
- ☐ SPINA BIFIDA
- ☐ SPINA BIFIDA WITH HYDROCEPHALUS

Spina Bifida includes Meningomyelocele, Myelomeningocele, Meningocele and Lipmeningocele

57. SPINA BIFIDA TYPE:
- ☐ OPEN
- ☐ CLOSED
- ☐ UNSPECIFIED

FOR ALL NTD CASES: YES NO UNKNOWN

58. IS HYDROCEPHALY PRESENT? ☐ ☐ ☐

59. NTD PART OF A SYNDROME? ☐ ☐ ☐

60. IF YES, SPECIFY SYNDROME:

61. ARE OTHER ABNORMALITIES PRESENT? ☐ ☐ ☐
Specify:

PRENATAL GENETIC PROCEDURES PERFORMED TO DETECT NEURAL TUBE DEFECT

PRENATAL PROCEDURE	DATE PROCEDURE PERFORMED *(MM/DD/YYYY)*	NAME & ADDRESS OF FACILITY or PDC CODE WHERE PROCEDURE WAS PERFORMED	GESTATIONAL AGE OF FETUS IN WEEKS/DAYS	DID PROCEDURE DETECT NTD?
62. ULTRASOUND: ☐	/ /		/	YES ☐ NO ☐
63. AMNIOCENTESIS: ☐	/ /		/	YES ☐ NO ☐

64. IF AMNIO PERFORMED, PROVIDE THE AF-AFP LEVEL (in M.o.M.) .

65. AF-AChE RESULT: ☐ POSITIVE ☐ NEGATIVE ☐ NOT PERFORMED

66. IF NTD WAS DIAGNOSED POSTNATALLY, WHEN DIAGNOSED?
- ☐ AT THE TIME OF LIVE BIRTH
- ☐ AT PHYSICAL EXAMINATION
- ☐ AT TIME OF STILLBIRTH
- ☐ OTHER *Specify Other:*

67. DATE OF POSTNATAL DIAGNOSIS: / /

68. WAS THE FETAL ABNORMALITY CONFIRMED? ☐ YES ☐ NO ☐ PENDING ☐ NOT POSSIBLE ☐ UNKNOWN

69. METHOD USED FOR CONFIRMATION OF FETAL ABNORMALITY:
☐ AUTOPSY / PATHOLOGY ☐ VISUAL EXAM ☐ OTHER *Specify:*
☐ ULTRASOUND ONLY ☐ ULTRASOUND & AMNIO

70. WHAT WAS THE SOURCE OF SOURCES OF YOUR CONFIRMATION?
☐ ULTRASOUND REPORT ☐ AMNIO REPORT ☐ CLINICIAN NOTES ☐ UNKNOWN
☐ AUTOPSY / PATH REPORT ☐ DELIVERY ROOM REPORT ☐ OUTCOME OF PREGNANCY ☐ OTHER *Specify:*

PRIVACY STATEMENT

The Information Practices Act of 1977 (Civil Code 1798 et. seq.) requires that the following details be provided when a form is used to obtain information from individuals. The data requested in this form are required by the Genetic Disease Branch (GDB) of the California Department of Health Services and are mandated by C.C.R.17 Section 6532. These data are used to provide information to subjects on the prevention of birth defects, to determine prevalence of chromosomal and neural tube defects and to monitor trends of occurrence. They will also be used to determine the effectiveness of the California Expanded Alpha Fetoprotein Screening Program. It is mandatory that health professionals completing this form provide complete and accurate information. The records maintained by the GDB are confidential as defined in Civil Code 1798.34 and are exempt from access by any individual except licensed medical personnel designated by the subject. The information may also be used in special studies as defined in Health and Safety Code 100330. The furnishing of such information to the Department or its authorized representative, or any other cooperating individual, agency or organization in any such special study shall not subject any person, hospital or other organization furnishing such information to any actions or damages.